

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Chesterton</u> LENGTH OF STAY (in this place) <u>20 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesterton - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Carroll <u>THEODORE CARROLL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 21</u> 19 <u>56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2/24/1895</u>
9. AGE last birthday <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>W. S. A. Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		12. CITIZEN OF WHAT COUNTRY? <u>1956</u>	
13. FATHER'S NAME <u>John T. Canall</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte E. Savinester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1918</u>		16. SOCIAL SECURITY No. <u>221-20-4861</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Canall - Chesterton Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Coronary thrombosis -</u>		<u>5-10 minutes</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>Coronary insufficiency -</u>	
<u>Coronary arteriosclerosis - several years</u>		<u>several years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-21</u> , 19 <u>56</u> to <u>1-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>56</u> , and that death occurred at <u>2 or 8</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Edgar L. Lane M.D.</u>		ADDRESS <u>Chesterton Md</u>	
DATE SIGNED <u>1-23-56</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>1-24</u>		NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>	
DATE REC'D BY LOCAL REG. <u>1-23</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill</u>	
REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

998

CERTIFICATE OF DEATH

Reg. Dist. No. 25/.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Barclay</u>		6 Yrs.		OR TOWN <u>Rural Marydel</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
None				None			
3. NAME OF DECEASED: (First) <u>Edward</u>		(Middle) <u>E.</u>		(Last) <u>Daniels</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>12</u> <u>56</u> <u>19</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>3/21/1870</u>	
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		9. AGE last birthday <u>85</u> yrs.	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Simon Daniels</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mary Daniels Barclay, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO <u>Arterial Sclerosis</u>							
(C) <u>Finally</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION: <u>W</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 1955, to <u>Jan 12</u> , 1956, that I last saw the deceased alive on <u>Jan 12</u> , 1956, and that death occurred at <u>530 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. H. H. H. H.</u>		M. D.		ADDRESS <u>Eastview, Md.</u>		DATE SIGNED <u>1/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1/15/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Mt. Zion</u>		LOCATION (City, town, or county) (State): <u>Near Marydel, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>1/14/56</u>		REGISTRAR'S SIGNATURE: <u>Edgar L. Kane</u>		FURNERAL DIRECTOR: <u>J. E. Boulais</u>		ADDRESS: <u>Greenboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

RECEIVED

Handwritten text, likely a signature or name, possibly "G. W. White" or similar, written in cursive.

Handwritten text, possibly "G. W. White" or similar, written in cursive.

Handwritten text, possibly "for 1956" or similar, written in cursive.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

999

00978

Reg. Dist. 254

No. 257

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Princess Anne</u>		<u>all life</u>		TOWN <u>Princess Anne P. Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Chas.</u>		(Middle) <u>Edward</u>		(Last) <u>Thigdon</u>		(Month) (Day) (Year) <u>Jan 17 1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>May 6-1928</u>	9. AGE last birthday: <u>27</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>new Brunswick Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		
13. FATHER'S NAME: <u>Chas. C. Thigdon</u>				14. MOTHER'S MAIDEN NAME: <u>Belle Sparks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Sister Mrs Frances Lyon - Princess Anne P. Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Very frail & under nourished - died in an</u> DUE TO Antecedent cause(s) (b) <u>Epileptic seizure -</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>He was an imbecile, unable to walk or talk and an epileptic</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER					
<u>W. Henry Fisher - Centerville Md</u>		DEPUTY MEDICAL EXAMINER					
		ASSISTANT MEDICAL EXAM. <u>1/18-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Chestnut Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1-18-56</u>		REGISTRAR'S SIGNATURE <u>Helen Aldridge</u>		24. FUNERAL DIRECTOR <u>Boston Ben Centerville, Maryland</u>		ADDRESS	

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JAN 25 1956
BUREAU V. S.

1956

00979

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 254

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne's</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Queen Anne's</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<u>TOWN near Queenstown</u>		<u>Queenstown</u>	<u>1870</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Mary</u>	(Middle) <u>E</u>	(Last) <u>Larimore</u>	(Month) <u>Jan</u> (Day) <u>20</u> (Year) <u>1956</u>
(Type or Print)			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u>	8. DATE OF BIRTH: <u>July 6-1879</u>
			9. AGE last birthday: <u>76</u> yrs.
			IF UNDER 1 YEAR IF UNDER 24 HRS.
			Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>	
11. BIRTHPLACE (State or foreign country): <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>?</u> <u>Fox</u>		14. MOTHER'S MAIDEN NAME: <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>James Reynolds, Queenstown, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Found dead on floor of bedroom</u>		
DUE TO <u>Exposure</u>		
Antecedent cause(s) (b) <u>No fire in house</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher, Centerville, Md.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/21-56</u>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Jan. 24-56</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Peter's Church</u>
LOCATION (City, town, or county) (State): <u>Queenstown, Maryland</u>	24. FUNERAL DIRECTOR: <u>W. Evans, Sackin & Porter, Bldg. Centerville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 24 1956</u>	REGISTRAR'S SIGNATURE: <u>Helen M. Adredge</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JAN 27 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00980

1901

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>New York</u>	
CITY OR TOWN <u>Rural 1 Chestertown</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY OR TOWN <u>New York</u>		69X-9	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>1351 2nd Ave</u>		(If rural give location) <u>v</u>	
3. NAME OF DECEASED (First) <u>Helen</u> (Middle) <u>Theresa</u> (Last) <u>Neobegier</u>				4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MAY 28, 1904</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Warner</u>				14. MOTHER'S MAIDEN NAME <u>Agatha Webber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>082-14-2031</u>		17. INFORMANT & ADDRESS <u>Mrs Anthony Libersky, Chestertown, RI</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 mos</u>	
156.1 IMMEDIATE CAUSE (A) <u>Cancer of Liver</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November</u>, 19<u>55</u>, to <u>Jan 28</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan 27</u>, 19<u>56</u>, and that death occurred at <u>12:30 P.</u>M, from the causes and on the date stated above.							
SIGNATURE <u>ACB</u>				ADDRESS (Street, city, town, state) <u>Chestertown, Md</u>		DATE SIGNED <u>1-28-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>New York City</u>	
24. REC'D BY REGISTRAR <u>1-31</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u>		ADDRESS <u>Chestertown MD</u>	
DATE							

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00982
Reg. Dist.

No. 254

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>near Luddenstown</u> TOWN <u>near Luddenstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Wye Mills</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) (First) <u>Adam</u> (Middle) <u>Hammeton</u> (Last) <u>Reid</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 21</u> 19 <u>56</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Apr 5-1888</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Hardeman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Cattle</u>	
11. BIRTHPLACE (State or foreign country): <u>British Isles</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>	
13. FATHER'S NAME: <u>Wm Reid</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Hammeton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>188-26-9598</u>	
17. INFORMANT & ADDRESS: <u>Eliza S. Reid (Wife) Wye Mills Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>1</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. TIME (Month) (Day) (Year) (Hour) OF INJURY		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/> SIGNATURE <u>W. Henry Fisher, Centerville Md</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/23-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan 24-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Jan 24 56</u>		REGISTRAR'S SIGNATURE <u>Helen M. Adridge</u>	
24. FUNERAL DIRECTOR <u>W. Evans & Son, Centerville Md.</u>		ADDRESS	

W. A. 11

W. A. 11

W. A. 11

1003

CERTIFICATE OF DEATH

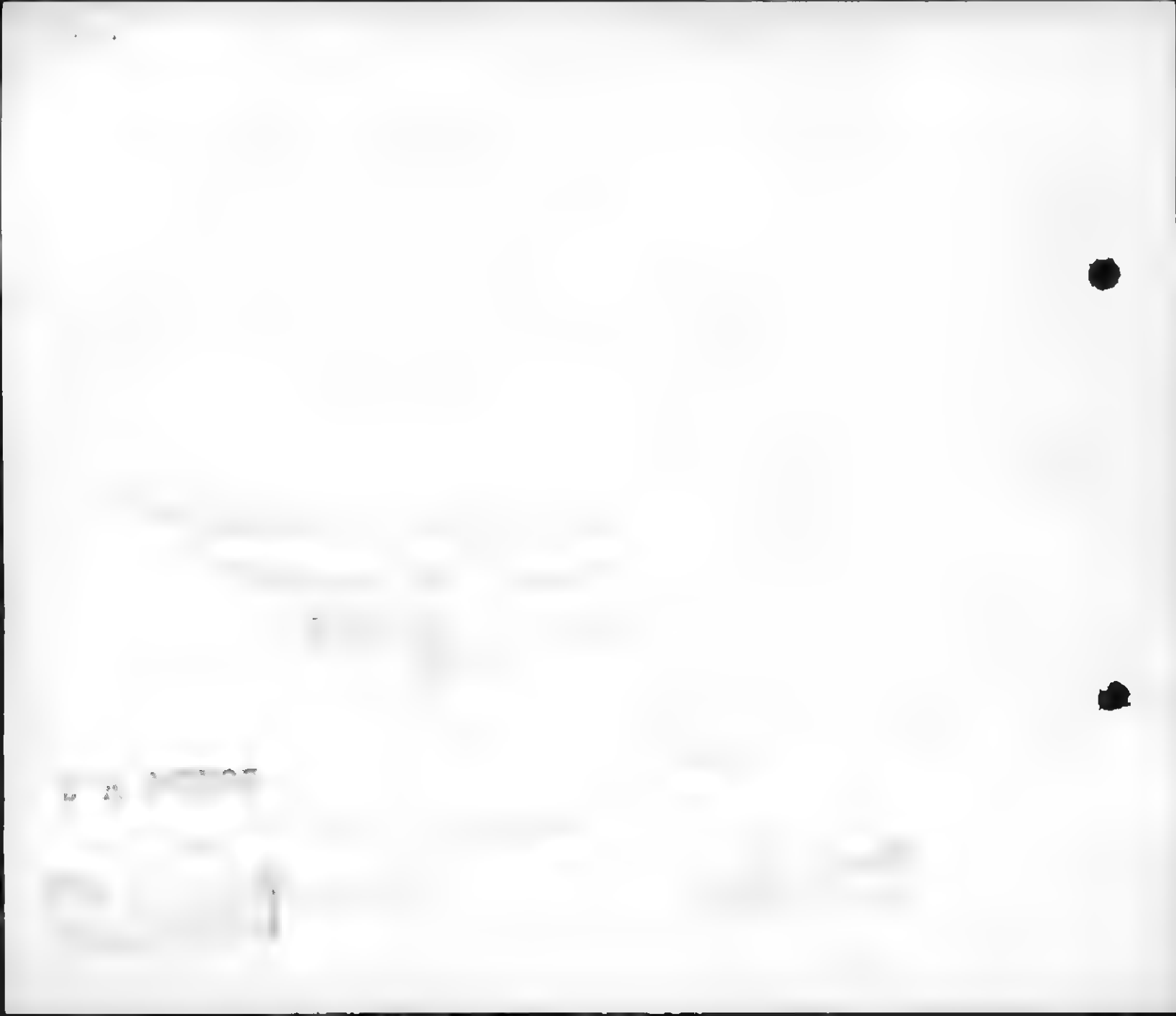
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Rural Barclay</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Barclay</u> STREET ADDRESS (If rural give location) <u>none</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Herman</u> <u>Toulson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>10</u> <u>56</u> <u>19</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Specified</u>	8. DATE OF BIRTH: <u>9/2/1871</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John M. Toulson</u>		14. MOTHER'S MAIDEN NAME: <u>Francis O. Coleman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Beulah Toulson Barclay, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Cardiac Arrhythmias</u>			
ANTECEDENT CAUSE (B) <u>Chronic Myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture</u>			
19A. DATE OF OPERATION: <u>no</u>		19B. MAJOR FINDINGS OF OPERATION <u>no</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) <u>no</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY <u>no</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 26, 1955</u> , to <u>Jan 10, 1956</u> that I last saw the deceased alive on <u>Dec 2, 1956</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u> DATE SIGNED <u>1/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/13/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Busic</u>		LOCATION (City, town, or county) (State) <u>Near Barclay, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

00983

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1904

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jacob</u>	(Middle) <u>Henry</u>	(Last) <u>Wilson</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 1, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH WILSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>ANNIE CARTER - QUEENSTOWN MD</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Tubercular Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Heart Failure2 weeks(c) Hypertensive Arteriosclerosis C-V Disease 2 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April, 1953, to Jan, 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 10:48 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/11/56</u>	<u>Byrons Cemetery</u>	<u>Greenville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 11 - 1956</u>	<u>Helen M. Aldridge</u>	<u>James B. Doherty</u>	<u>Porton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 13 1936

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Queen Anne's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Queen Anne's</i>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Centerville</i>	LENGTH OF STAY (in this place) <i>20 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Centerville</i>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last) <i>JOHN ALEXANDER WOODROW</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 13 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 15 - 1890</i>
9. AGE last birthday <i>65</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Printing & Publishing</i>	11. BIRTHPLACE (State or foreign country) <i>Harrow Ontario Canada</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Duncan Woodrow</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Bishop</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-3949</i>	
(If Yes, give war or dates of service) <i>No</i>		17. INFORMANT & ADDRESS <i>Pearl O. Woodrow - Centerville, Md.</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Cerebral Haemorrhage</i>		<i>5 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension Cardiovascular Disease</i>		<i>years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerosis Coronary Artery Disease</i>		<i>years</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Coronary Failure</i>		<i>months</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 7 1956</i> to <i>Jan 13 1956</i> , that I last saw the deceased alive on <i>Jan 13 1956</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>A.T. Lester</i>		ADDRESS (Street, city, town, state) <i>Centerville Md</i>	
DATE SIGNED <i>1-15-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>Jan 15-56</i>	
NAME OF CEMETERY OR CREMATORY <i>Christiansburg</i>		LOCATION (City, town, or county) (State) <i>Centerville Maryland</i>	
24. REC'D BY REGISTRAR <i>Chas. Remington</i>		REGISTRAR'S SIGNATURE <i>Chas. Remington</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Patton</i>		ADDRESS <i>Butts Co. Centerville Md</i>	
DATE <i>1/14/56</i>			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

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BUREAU V. S.

JAN 20 1922

RECEIVED